FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 S. HARLEM AVE. (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3780344

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,012	3,012	8
9	SNF/PED					9
10	ICF	31,112	10,989		42,101	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,112	10,989	3,012	45,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.66%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/2/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/2/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,537

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,865	24,925	6,847	231,637		231,637		231,637			1
2	Food Purchase		202,424		202,424	(33,945)	168,479	(1,903)	166,576			2
3	Housekeeping	124,844	33,524		158,368		158,368		158,368			3
4	Laundry	79,469	14,479	1,246	95,194		95,194		95,194			4
5	Heat and Other Utilities			105,113	105,113		105,113	1,130	106,243			5
6	Maintenance	74,327	22,256	13,865	110,448		110,448	8,642	119,090			6
7	Other (specify):*			8,369	8,369		8,369	617	8,986			7
8	**TOTAL General Services**	478,505	297,608	135,440	911,553	(33,945)	877,608	8,486	886,094			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	1,899,829	55,589	49,856	2,005,274		2,005,274	(2,251)	2,003,023			10
10a	Therapy			14,284	14,284		14,284		14,284			10a
11	Activities	208,409	10,035	2,520	220,964		220,964		220,964			11
12	Social Services			2,117	2,117		2,117		2,117			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,108,238	65,624	70,877	2,244,739		2,244,739	(2,251)	2,242,488			16
	C. General Administration											
17	Administrative	64,236		156,560	220,796		220,796	20,463	241,259			17
18	Directors Fees											18
19	Professional Services			56,108	56,108		56,108	3,074	59,182			19
20	Dues, Fees, Subscriptions & Promotions			45,803	45,803		45,803	(32,848)	12,955			20
21	Clerical & General Office Expenses	166,405	21,389	211,334	399,128		399,128	(133,337)	265,791			21
22	Employee Benefits & Payroll Taxes			437,355	437,355	33,945	471,300		471,300			22
23	Inservice Training & Education			2,498	2,498		2,498		2,498			23
24	Travel and Seminar							622	622			24
25	Other Admin. Staff Transportation			2,914	2,914		2,914		2,914			25
26	Insurance-Prop.Liab.Malpractice			139,263	139,263		139,263	3,391	142,654			26
27	Other (specify):*							23,151	23,151			27
28	**TOTAL General Administration**	230,641	21,389	1,051,835	1,303,865	33,945	1,337,810	(115,484)	1,222,326			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,817,384	384,621	1,258,152	4,460,157		4,460,157	(109,249)	4,350,908			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,252	
	REPAIRS & MAINTENANCE		595	
			0	6,847
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,246	
			0	1,246
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,249	
	ELECTRICITY		39,614	
	WATER		19,250	
	CABLE TV - LOBBY		0	
			0	105,113
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,417	
	PAINTING & DECORATING		18	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,310	
	ELEVATOR MAINTENANCE & REPAIR		6,220	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		0	
			0	
			0	
			0	13,865
7	**OTHER**			
	SCAVENGER		8,369	
	SECURITY SERVICE		0	8,369
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,100	2,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	44,639	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,722	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	495	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	49,856
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,484	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,845	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	3,955	14,284
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,520	
			0	2,520
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,117	
			0	2,117
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	156,560	156,560
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,629	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	50,479	
			0	56,108
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	31,773	
	EMPLOYEE WANT ADS	XIX F	987	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8,093	
	LICENSES & PERMITS	XIX F	2,671	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,100	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	179	45,803
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		43	
	EQUIPMENT REPAIR & MAINTENANCE		13,853	
	OUTSIDE CLERICAL SERVICES		179,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,210	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,028	
	MESSENGER SERVICE		0	
			0	211,334

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	210,402	
	UNEMPLOYMENT COMPENSATION	XIX D	15,315	
	WORKERS COMPENSATION INSURANCI	XIX D	94,332	
	HOSPITALIZATION INSURANCE	XIX D	112,146	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,160	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	437,355
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,498	2,498
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,914	2,914
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		139,263	139,263
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,258,152

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			48,023	48,023		48,023	140,677	188,700			30
31	Amortization of Pre-Op. & Org.							4,939	4,939			31
32	Interest			64,899	64,899		64,899	395,093	459,992			32
33	Real Estate Taxes			157,450	157,450		157,450	2,742	160,192			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			16,457	16,457		16,457	7,551	24,008			35
36	Other (specify):*											36
37	**TOTAL Ownership**			776,069	776,069		776,069	61,762	837,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,787	67,314	145,101		145,101	(2,633)	142,468			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		77,787	147,249	225,036		225,036	(2,633)	222,403			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,817,384	462,408	2,181,470	5,461,262		5,461,262	(50,120)	5,411,142			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(69,584)	30		9
10	Interest and Other Investment Income	(1,740)	32		10
11	Discounts, Allowances, Rebates & Refunds	(588)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,315)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,210)	21		18
19	Entertainment		20		19
20	Contributions	(2,100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(31,773)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	508			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (108,802)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	58,682		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 58,682		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (50,120)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRIDGEVIEW HEALTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 508	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	508		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,903)	0	0	0	0	0	0	0	0	0	0	(1,903)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,130	0	0	0	0	0	0	0	0	1,130	5
6	Maintenance	508	0	901	7,233	0	0	0	0	0	0	0	8,642	6
7	Other (specify):*	0	0	0	0	617	0	0	0	0	0	0	617	7
8	**TOTAL General Services**	(1,395)	0	2,031	7,233	617	0	0	0	0	0	0	8,486	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(2,251)	0	0	0	0	0	(2,251)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(2,251)	0	0	0	0	0	(2,251)	16
	C. General Administration													
17	Administrative	0	(156,560)	0	177,023	0	0	0	0	0	0	0	20,463	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,074	0	0	0	0	0	0	0	0	3,074	19
20	Fees, Subscriptions & Promotions	(33,873)	0	1,025	0	0	0	0	0	0	0	0	(32,848)	20
21	Clerical & General Office Expenses	(2,210)	(179,200)	41,321	6,752	0	0	0	0	0	0	0	(133,337)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	622	0	0	0	0	0	0	0	0	622	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,391	0	0	0	0	0	0	0	0	3,391	26
27	Other (specify):*	0	0	7,064	0	16,087	0	0	0	0	0	0	23,151	27
28	**TOTAL General Administration**	(36,083)	(335,760)	56,497	183,775	16,087	0	0	0	0	0	0	(115,484)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,478)	(335,760)	58,528	191,008	16,704	(2,251)	0	0	0	0	0	(109,249)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(69,584)	206,440	3,821	0	0	0	0	0	0	0	0	140,677	30
31	Amortization of Pre-Op. & Org.	0	4,939	0	0	0	0	0	0	0	0	0	4,939	31
32	Interest	(1,740)	393,216	3,617	0	0	0	0	0	0	0	0	395,093	32
33	Real Estate Taxes	0	0	2,742	0	0	0	0	0	0	0	0	2,742	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	7,551	0	0	0	0	0	0	0	0	7,551	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(71,324)	115,355	17,731	0	0	0	0	0	0	0	0	61,762	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(2,633)	0	0	0	0	0	(2,633)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(2,633)	0	0	0	0	0	(2,633)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(108,802)	(220,405)	76,259	191,008	16,704	(4,884)	0	0	0	0	0	(50,120)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 156,560	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (156,560)	1
2	V	21	BOOKKEEPING SERVICES	179,200	" "			(179,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES LLC			(489,240)	7
8	V	30	DEPRECIATION		" "		206,440	206,440	8
9	V	31	AMORTIZATION		" "		4,939	4,939	9
10	V	32	INTEREST		" "		393,216	393,216	10
11	V								11
12	V								12
13	V								13
14	Total			$ 825,000			$ 604,595	$ * (220,405)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,130	$ 1,130	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	901	901	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "	100.00%			17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	3,074	3,074	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	1,025	1,025	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	41,321	41,321	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	622	622	21
22	V	26	INSURANCE		" " "	100.00%	3,391	3,391	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	7,064	7,064	23
24	V	30	DEPRECIATION		" " "	100.00%	3,821	3,821	24
25	V	32	INTEREST		" " "	100.00%	3,617	3,617	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	2,742	2,742	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	7,551	7,551	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 76,259	$ * 76,259	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 7,233	$ 7,233	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	40,259	40,259	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	59,185	59,185	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	33,976	33,976	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	11,128	11,128	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	13,890	13,890	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	18,585	18,585	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	6,752	6,752	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 191,008	$ * 191,008	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS		$ 617	$ 617	15
16	V	15	EMP. BEN. - SUE G.		" " "				16
17	V	27	EMP.BEN. - M. MAUER		" " "		1,277	1,277	17
18	V	27	EMP. BEN. - M. AARON		" " "		1,970	1,970	18
19	V	27	EMP. BEN. - F. AARON		" " "		5,701	5,701	19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "				20
21	V	27	EMP. BEN. - S. KOPLIN		" " "				21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "		978	978	22
23	V	27	EMP. BEN. - E. CASSON		" " "				23
24	V	27	EMP. BEN. - S. BOGEN		" " "				24
25	V	27	EMP. BEN. - S. LEVY		" " "		2,009	2,009	25
26	V	27	EMP. BEN. - H. ALTER		" " "				26
27	V	27	EMP. BEN. - NON-OWNER		" " "		2,822	2,822	27
28	V	27	EMP. BEN. - S. AARON		" " "		1,330	1,330	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 16,704	$ * 16,704	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 14,267	DYNAMIC REHAB CONSULTANTS LLC	100.00%	$ 14,267	$	15
16	V	19	PROFESSIONAL FEES		" " "	100.00%			16
17	V	22	EMPLOYEE BENEFITS		" " "	100.00%			17
18	V	39	ANCILLARY SERVICES	66,422	" " "	100.00%	66,422		18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	8,919	LINCOLN MEDICAL SUPPLIES, INC.		6,668	(2,251)	21
22	V	39	ANCILLARY EXPENSE	10,431	" " "		7,798	(2,633)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,039			$ 95,155	$ * (4,884)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 40,259	17-7	1
2	MAURY AARON		ADMINISTRATIVE					SALARY	59,185	17-7	2
3	SHARON AARON		CLERICAL					SALARY	6,752	21-7	3
4	FRED AARON		ADMINISTRATIVE					SALARY	33,976	17-7	4
5	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	11,128	17-7	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	7,233	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 158,533		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	423,801	12	$ 10611	$	45,113	$ 1,130	1
2	6	REPAIR & MAINT.	" "	423,801	12	8462		45,113	901	2
3	7	EMP. BEN. - GEN, SERVICES	" "	423,801	12			45,113	0	3
4	19	PROFESSIONAL FEES	" "	423,801	12	28879		45,113	3,074	4
5	20	DUES AND SUBSCRIPTION	" "	423,801	12	9628		45,113	1,025	5
6	21	CLERICAL & GENERAL	" "	423,801	12	388179	279,093	45,113	41,321	6
7	24	SEMINARS AND TRAVEL	" "	423,801	12	5844		45,113	622	7
8	26	INSURANCE	" "	423,801	12	31856		45,113	3,391	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	423,801	12	66362		45,113	7,064	9
10	30	DEPRECIATION	" "	423,801	12	35898		45,113	3,821	10
11	32	INTEREST	" "	423,801	12	33975		45,113	3,617	11
12	33	REAL ESTATE TAXES	" "	423,801	12	25761		45,113	2,742	12
13	35	EQUIPMENT RENTAL	" "	423,801	12	70935		45,113	7,551	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 76,259	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 59,901	$ 59,901	5	$ 7,233	1
2	10	NURSING CMP. - SUE G.	" "							2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	373,726	373,726	4	40,259	3
4	17	ADMIN. CMP. - M. AARON	" "	40	9	490,141	490,141	5	59,185	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,118	191,118	8	33,976	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	40	3	49,500	49,500			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	69,097	69,097			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	77,417	77,417	6	11,128	8
9	17	ADMIN. CMP. - E. CASSON	" "							9
10	17	ADMIN. CMP. - S. BOGEN	" "	11	2	40,545	40,545			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	11	128,818	128,818	5	13,890	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	11	153,735	153,375	5	18,585	13
14	21	CLERICAL. CMP. - S. AARON	" "	40	11	62,676	62,676	4	6,752	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,674	$ 1,708,314		$ 191,008	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,106	$	5	$ 617	1
2	15	EMP. BEN. - SUE G.	" "							2
3	27	EMP.BEN. - M. MAUER	" "	40	11	11,858		4	1,277	3
4	27	EMP. BEN. - M. AARON	" "	45	9	16,312		5	1,970	4
5	27	EMP. BEN. - F. AARON	" "	45	6	32,071		8	5,701	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	40	3	26,160				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	7	26,142				7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	6,801		6	978	8
9	27	EMP. BEN. - E. CASSON	" "							9
10	27	EMP. BEN. - S. BOGEN	" "	11	2	3,320				10
11	27	EMP. BEN. - S. LEVY	" "	45	11	18,630		5	2,009	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	4,292				12
13	27	EMP. BEN. - NON-OWNER	" "	45	11	23,348		5	2,822	13
14	27	EMP. BEN. - S. AARON	" "	40	11	12,346		4	1,330	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 16,704	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						14,267	2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "						66,422	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES							6,668	8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						7,798	9
10	39	ANCILLARY EXPENSE	" "							10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 95,155	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$54,580.85	7/01	$ 5,722,000	$ 5,621,250			$ 393,216	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				530,000		PRIME+	24,200	6
7			X	INSURANCE FINANCING							3,363	7
8	RELATED PARTY	X									37,336	8
9	TOTAL Facility Related				$54,580.85		$ 5,722,000	$ 6,151,250			$ 458,115	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,722,000	$ 6,151,250			$ 458,115	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 185,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 169,450	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,550)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 173,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 157,450	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	175,735	8
1999	170,762	9
2000	177,631	10
2001	180,886	11
2002	169,450	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 169,450.32	$ 169,450.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 169,450.32	$ 169,450.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 207,651	39	$ 131,907	$ (75,744)	$ 1,189,752	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		391	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	181	15	181		2,210	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		32,391	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		546	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		1,989	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		265	14
15	CARPET INSTALL			1995	1,303	33	39	33		271	15
16	RAIL BUMPER			1995	917	24	39	24		193	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	136	39	136		1,037	17
18	PAINTING WORK			1996	8,400	215	39	215		1,586	18
19	WALL COVERING			1996	1,435	37	39	37		270	19
20	FRONT LOBBY/WINDOW,DOOR WORK			1997	2,509	65	39	65		415	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		423	21
22	CONDENCING UNIT			1999	3,824	98	39	98		456	22
23	DRAPES			1999	5,369	138	39	138		606	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		981	24
25	DOOR WORK			1999	10,490	269	39	269		1,168	25
26	KITCHEN CABINETS			1999	5,832	150	39	150		669	26
27	TILES			2000	8,855	322	27.5	322		1,102	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		438	28
29	ROD MAIN SEWER			2000	1,100	40	27.5	40		138	29
30	DRAPERIES			2001	2,118	303	7	303		1,341	30
31	RECEPTION DESK/DOOR			2002	9,534	511	27.5	343	(168)	346	31
32	FLOORING / BUMPER GUARDS			2002	11,198	404	27.5	404		408	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,312	27.5	1,312		1,312	33
34	WIRING,MOTOR			2002	9,224	393	27.5	393		336	34
35	HANDRAILS & GUARDS			2003	7,811	130	27.5	130		130	35
36	FENCES & CONCRETE			2003	4,023	2,079	15	2,079		2,079	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BOARDS	2003	$ 1,752	$ 29	27.5	$ 1,752	$ 1,723	$ 1,752	37
38	COIL	2003	806	13	27.5	806	793	806	38
39	ELEVATOR REPAIRS	2003	3,991	68	27.5	3,991	3,923	3,991	39
40	WINDOW TREATMENTS	2003	1,672	28	27.5	1,672	1,644	1,672	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	111	27.5	6,701	6,590	6,701	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,364,140	$ 218,226		$ 156,987	$ (61,239)	$ 1,258,171	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 261,576	$ 20,466	$ 26,157	$ 5,691	10	$ 167,314	71
72	Current Year Purchases	31,347	16,982	1,567	(15,415)	10	1,567	72
73	Fully Depreciated Assets	1,820					1,820	73
74	Related Party	28,970	1,596	2,275	679	10	13,491	74
75	TOTALS	$ 323,713	$ 39,044	$ 29,999	$ (9,045)		$ 184,192	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing, Housekeeping, Main	1991 Dodge Van	1991	$ 24,971	$	$	$	4 years	$ 24,971	76
77	Related Party			5,993	1,015	1,715	700		5,873	77
78										78
79										79
80	TOTALS			$ 30,964	$ 1,015	$ 1,715	$ 700		$ 30,844	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,022,817	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 258,285	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 188,701	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,584)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,473,207	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 489,240			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 489,240 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,863 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		Elgin Toyota	$ 470.00	$ 3,289	17
18		American Express	840.00	10,082	18
19		Toyota	445.00	2,225	19
20	PAYROLL DEDUCTION			(4,002)	20
21	TOTAL		$ #######	$ 11,594	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

STATE OF ILLINOIS
0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 31,480	$		$ 31,480	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,061			1,061	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			34,773			34,773	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				50,306		50,306	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB,RADIOLOGY Other (specify): RENTALS	39-2					27,481		27,481	13
14	TOTAL			$		$ 67,314	$ 77,787		$ 145,101	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	631,499		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,295		6
7	Other Prepaid Expenses	3,259		7
8	Accounts Receivable (owners or related parties)	21,337		8
9	Other(specify): Real Estate Tax Escrow	101,905		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 813,295	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	272,138		15
16	Equipment, at Historical Cost	319,714		16
17	Accumulated Depreciation (book methods)	(327,590)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	528,400		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 792,662	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,605,957	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 531,082	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	530,000		29
30	Accrued Salaries Payable	341,904		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,884		31
32	Accrued Real Estate Taxes(Sch.IX-B)	173,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,588,870	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,588,870	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,087	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,605,957	$	48

*(See instructions.)

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 211,136	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 211,136	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(194,049)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (194,049)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,087	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,235,674	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,235,674	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	29,211	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 29,211	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,740	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,740	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Discounts Earned	588	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 588	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,267,213	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	911,553	31
32	Health Care	2,244,739	32
33	General Administration	1,303,865	33
	B. Capital Expense		
34	Ownership	776,069	34
	C. Ancillary Expense		
35	Special Cost Centers	145,101	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,461,262	40
41	**Income before Income Taxes (line 30 minus line 40)****	(194,049)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (194,049)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,653	1,980	$ 61,090	$ 30.85	1
2	Assistant Director of Nursing	1,357	1,619	46,511	28.73	2
3	Registered Nurses	9,515	10,818	265,210	24.52	3
4	Licensed Practical Nurses	25,961	29,341	588,450	20.06	4
5	Nurse Aides & Orderlies	87,490	96,784	906,483	9.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,026	21,436	208,409	9.72	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,891	3,419	45,102	13.19	13
14	Head Cook	3,184	3,437	28,180	8.20	14
15	Cook Helpers/Assistants	15,804	17,268	126,583	7.33	15
16	Dishwashers					16
17	Maintenance Workers	3,795	4,322	74,327	17.20	17
18	Housekeepers	14,958	16,505	124,844	7.56	18
19	Laundry	9,318	10,324	79,469	7.70	19
20	Administrator	2,037	2,364	64,236	27.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,313	10,828	166,405	15.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,910	2,205	32,085	14.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,212	232,650	$ 2,817,384 *	$ 12.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	242	$ 6,252	1-3	35
36	Medical Director	42	2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	118	4,722	10-3	39
40	Physical Therapy Consultant	71	2,484	10a-3	40
41	Occupational Therapy Consultant	224	7,845	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	113	3,955	10a-3	43
44	Activity Consultant	56	2,520	11-3	44
45	Social Service Consultant	41	2,117	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	907	$ 31,995		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 695	10-3	50
51	Licensed Practical Nurses	824	34,649	10-3	51
52	Nurse Aides	377	9,295	10-3	52
53	TOTAL (lines 50 - 52)	1,217	$ 44,639		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMIN	0	$ 64,236
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,236

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 156,560
TOTAL (agree to Schedule V, line 17, col. 3)	$ 156,560
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEMS	DATA PROCESSING	$ 5,409
ACCU MED SVC	DATA PROCESSING	220
KRUPNICK BOKOR	ACCOUNTING	30,026
FROST RUTTENBERG	ACCOUNTING	270
SACHNOFF WEAVER	LEGAL	6,045
SIDNEY BERGER	LEGAL	1,725
FINKEL MARTWICK	LEGAL	4,736
CHICAGO LEGAL CLINIC	LEGAL	150
ECONOCARE	PURCHASING CONSLT	2,700
PERSONNEL PLANNERS	UC CONSULTANT	1,287
DART CHART	MEDICARE CONSULTANT	3,540
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 56,108

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 94,332
Unemployment Compensation Insurance		15,315
FICA Taxes		210,402
Employee Health Insurance		112,146
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		5,160
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	987
Health Care Worker Background Check	179
(Indicate # of checks performed 15)	
MARKETING/ADV/PROMO	31,773
TRUST/FRANCHISE/CONTRIB/ETC	2,100
LICENSES & PERMITS	2,271
DUES & SUBSCRIPTIONS	8,093
MGMT CO ALLOCATION	1,025
TRUST/FRANCHISE/CONTRIB/ETC	(2,100)
Less: Public Relations Expense	(0)
Non-allowable advertising	(31,773)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,955

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MGMT CO ALLOCATION	622
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 622

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2000	$ 3,046	3	$ 508	$ 1,015	$ 1,015	$ 508	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,046		$ 508	$ 1,015	$ 1,015	$ 508	$	$	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNC LONG TERM CARE 7906**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,162** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees